Senate

General Assembly

File No. 78

February Session, 2004

Substitute Senate Bill No. 108

Senate, March 16, 2004

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING APPEALS OF HEALTH CARE DETERMINATIONS MADE TO THE INSURANCE COMMISSIONER.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-478n of the general statutes, as amended by section 94 of public act 03-278, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2004*):

(a) **[**On or after January 1, 1998, any**]** Any enrollee, or any provider acting on behalf of an enrollee with the enrollee's consent, who has exhausted the internal mechanisms provided by a managed care organization or utilization review company to appeal **[**a**]** the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner.

(b) (1) To appeal a [decision under the provisions of] denial or determination pursuant to this section [,] an enrollee or any provider acting on behalf of an enrollee shall, [within] not later than thirty days [from] after receiving [a] final written notice of the denial or determination from the enrollee's managed care organization or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by [said] the commissioner and shall include the filing fee [provided for] set forth in subdivision (2) of this [section] subsection and a general release executed by the enrollee for all medical records pertinent to the appeal. The managed care organization or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in subdivision (2) of this subsection.

(2) The filing fee shall be twenty-five dollars and shall be deposited [into] in the Insurance Fund established in section 38a-52a. If the commissioner finds that an enrollee is indigent or unable to pay the fee, the commissioner shall waive the enrollee's fee. Upon completion of the medical review pursuant to this section, the commissioner shall refund to the prevailing party any filing fee paid by the prevailing party.

(3) Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to an entity as defined in subsection (c) of this section.

(4) Upon receipt of the request for appeal from the commissioner, the entity conducting the appeal shall conduct a preliminary review of the appeal and accept [it] the appeal if such entity determines: (A) The individual was or is an enrollee of the managed care organization; (B) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (C) the enrollee has exhausted all internal appeal mechanisms provided; (D) the enrollee has provided all information required by the commissioner to make a preliminary determination including the appeal form, a copy of the

final decision of denial and a fully-executed release to obtain any necessary medical records from the managed care organization and any other relevant provider.

(5) Upon completion of the preliminary review, the entity conducting such review shall immediately notify the member or provider, as applicable, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons **[**therefore**]** why the appeal was not accepted for full review.

(6) If accepted for full review, the entity shall conduct such review in accordance with the regulations adopted by the commissioner, after consultation with the Commissioner of Public Health, in accordance with the provisions of chapter 54.

(c) To provide for such appeal the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall engage impartial health entities to provide for medical review under the provisions of this section. Such review entities shall include (1) medical peer review organizations, (2) independent utilization review companies, provided any such organizations or companies are not related to or associated with any managed care organization and (3) nationally recognized health experts or institutions approved by the commissioner.

(d) (1) Not later than five business days after receiving a written request for any information set forth in this subdivision a managed care organization whose enrollee is the subject of an appeal shall provide to the enrollee, the enrollee's designee or the commissioner: (A) A copy of the entire policy or contract between the enrollee and the managed care organization, and (B) written verification of whether the enrollee's managed care plan is fully insured, self-funded, or otherwise funded.

(2) Failure of the managed care organization to provide a copy of the entire policy or contract within said five-day period or before the expiration of the thirty-day period for appeals set forth in subdivision

(1) of subsection (b) of this section, whichever is later as determined by the commissioner, shall (A) create a presumption on the review entity, for purposes of accepting an appeal pursuant to subdivision (4) of subsection (b) of this section, that the benefit or service that is the subject of the appeal is a covered benefit under the applicable policy or contract and (B) entitle the Insurance Commissioner to require the managed care organization to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

[(d)**]** (e) The commissioner shall accept the decision of the **[**reviewing**]** review entity and the decision of the commissioner shall be binding.

[(e)**]** (f) Not later than January 1, 2000, the Insurance Commissioner shall develop a comprehensive public education outreach program to educate health insurance consumers of the existence of the appeals procedure established in this section. The program shall maximize public information concerning the appeals procedure and shall include, but not be limited to: (1) The dissemination of information through mass media, interactive approaches and written materials; (2) involvement of community-based organizations in developing messages and in devising and implementing education strategies; and (3) periodic evaluations of the effectiveness of educational efforts. The Managed Care Ombudsman shall coordinate the outreach program and oversee the education process.

This act shall take effect as follows:	
Section 1	*October 1, 2004*

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 05 $	FY 06 $
Office of Managed Care Ombudsman; Insurance Dept.	IF - Revenue Gain	Minimal	Minimal

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill revises external appeal provisions related to determinations made by managed care organizations. Currently, the Department of Insurance collects a $25 filing fee to appeal from the enrollee refused certification, unless the commissioner finds he is indigent or unable to pay. The bill requires both parties involved in a case regarding certification or denial of a claim to pay a $25 filing fee each, and requires that the prevailing party receive back the fee it paid. The bill also requires the managed care organization to provide a copy of the entire policy or contract in a specified time period. If the managed care organization fails to do so, the managed care organization is required to reimburse the department for expenses relating to the appeal, including any expenses the reviewing entity incurred. In addition, it is then presumed that the benefit or service that is the subject of the appeal is covered. The bill results in a minimal revenue gain to the Department of Insurance and the Office of Managed Care Ombudsman.

OLR Bill Analysis
sSB 108

AN ACT CONCERNING APPEALS OF HEALTH CARE DETERMINATIONS MADE TO THE INSURANCE COMMISSIONER.

SUMMARY:
The bill allows any enrollee, or any provider acting on the enrollee's behalf with the enrollee's consent, who has exhausted the internal mechanisms provided by a managed care organization or utilization review company to appeal the denial of a claim based on medical necessity to the insurance commissioner. Current law allows them to appeal a determination not to certify an admission, service, procedure, or extension of stay. The bill specifies that they may do so regardless of whether such determination was made before, during or after the admission, service, procedure, or extension of stay.

Current law requires the enrollee refused certification to pay a $25 filing fee to appeal, unless the commissioner finds he is indigent or unable to pay. The bill instead requires both parties in cases involving certification or denial of a claim to pay a $25 filing fee, and requires that the prevailing party receive back the fee it paid.

The bill requires a managed care organization whose enrollee is the subject of an appeal to provide certain information to the enrollee, his designee, or the commissioner, within five business days after receiving a written request. This information includes (1) a copy of the entire policy or contract between the enrollee and the managed care organization, and (2) written verification of whether the enrollee's managed care plan is fully insured, self-funded, or otherwise funded.

Under the bill, the failure of the managed care organization to provide a copy of the entire policy or contract within five-days after receiving the written request, or before the expiration of the thirty-day period for appeals provided by law, whichever is later, as determined by the commissioner, (1) creates a presumption for the entity reviewing the appeal that the benefit or service that is the subject of the appeal is a covered benefit under the applicable policy or contract and (2) entitles

the Insurance Commissioner to require the managed care organization to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses the review entity incurred.

The failure to provide these documents also subjects the violator to a late fee of $100 per day.

EFFECTIVE DATE: October 1, 2004

BACKGROUND

Related Law

Each managed care organization that does not file data, reports, or information required by certain insurance laws, including the law the bill amends, are subject to a $100 per day fine (CGS § 38a-478b).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 0